

ARRA and Other National Initiatives: Implications for Quality of Care

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Topics

- What are the implications of ARRA for improving the quality of healthcare through HIT?
- What are the impacts of “meaningful use”, certification, grant and implementation components?
- What national programs are working to make better quality and safety through HIT more feasible for more patients?
- What can you do, locally and nationally?

ARRA: Not Just a Feeding Frenzy



Assumptions

- The fundamental goal of HIT is better healthcare quality for more people
- Amenable US healthcare problems include preventive/chronic care, early recognition, adverse event prevention, appropriate resource utilization, and more
- Achievable through effective, well-used CDS, access to data, measurement, feedback
- Hampered by low penetrance of EHRs, missing segments, non-use/problematic use of CDS, cost and time

The goal

- **Widespread, commercially-available information systems being produced, purchased, and implemented, and helping to improve quality and efficiency in many venues**



Common Language: Terminology

- “Quality of care”
 - IOM – safe, effective, patient-centered, timely, equitable
- “Cost of care”
 - Resource use: price + volume
- “Efficiency of care”
 - Quality + cost
- “Value of care”
 - Quality + costs + preferences

*Drawn from IOM and AQA -- courtesy of NQF

ARRA key elements

Economic Stimulus Key Components

- Leadership
- Standards
- Certification
- Funding and Incentives
- Research and Development
- Education and Outreach
- Privacy and Security
- Additional Items

ARRA Funding

- Medicare incentive payments for 'meaningful use' of 'qualified' EHRs
- Medicaid incentive and HIT support payments
- \$2B of projects through ONC
- \$\$ for implementation expertise (HIT research center and regional HIT centers)
- \$\$ for workforce augmentation
- \$1.1B for comparative effectiveness research

ARRA Funding

- \$2.5B for broadband to support telemedicine and distance learning (in part)
- \$1.5B for renovation and construction of health centers
- \$85M for Indian Health Service HIT
- \$50M for Veterans Administration HIT

Medicare incentive

- Incentive payments for 'meaningful use' of qualified EHRs (starts in 2010-11; becomes penalty in 2015)
 - By hospitals (Typical: \$2M/yr)
 - By individual practitioners (up to \$44k/5yr)
 - Using qualified systems
 - Demonstrating HIE and care coordination for improving quality
 - Reporting on clinical quality measures

Medicare incentives - providers

- Up to \$44,000 over five years if ready in 2011
- Front-loaded (\$18-12-8-4-2k)
- Penalties for non-users start at 1% in 2015, go up to 3%

Medicare incentives - hospitals

- Up to \$11 million over four years if they are ready in 2011
- Initial amount of \$2 million, plus \$200 per-discharge payment for each discharge up to 23,000
- Pro-rated based on Medicare share and other factors
- Phased out over four years, then penalties for non-users starting 2015

Medicaid incentives

- Pays states to provide Medicaid incentive payments supporting cost of acquiring, implementing, maintaining EHRs
- Providers can earn Up to \$64,000
- Includes FQHCs, rural clinics, pediatricians and pedi hospitals, others
- Based on Medicaid share of practice

Incentive Programs

- Incentives actually total ~\$34B
 - CBO calculation
 - The \$17B figure is the net expenditure after including expected savings in health care costs

Qualified EHR

- A 'qualified EHR' is one that supports:
 - patient demographic and clinical health information, such as medical history and problem lists
 - CDS, CPOE, capture of healthcare quality info
 - Health information exchange (HIE) with other sources.
- Defined by ONC, with advice from certification body, standards body, policy committee

Qualified EHR

- EHR (+/- CPOE)
- eRx
- Smaller bites?:
 - Registry
 - Data repository / Exchange

Certification Language in ARRA

- “The National Coordinator, in consultation with the Director of the National Institute of Standards and Technology, shall keep or recognize a program or programs for the voluntary certification of health information technology as being in compliance with applicable certification criteria adopted under this subtitle.”

Timeline

- By 12/31/09 Secretary shall through rule-making process adopt an initial set of standards, implementation specifications and certification criteria
 - Can adopt previously adopted standards

Certification and Quality

- Current CCHIT criteria include a modest amount of CDS and reporting
 - Spread across various domains
 - Particularly basics, e.g., drug checks
 - More extensive CDS proposed for longer-term
- CCHIT Roadmap includes Quality and CDS subdomains (2010-2011)
- Proponents of more stringent and more lenient criteria

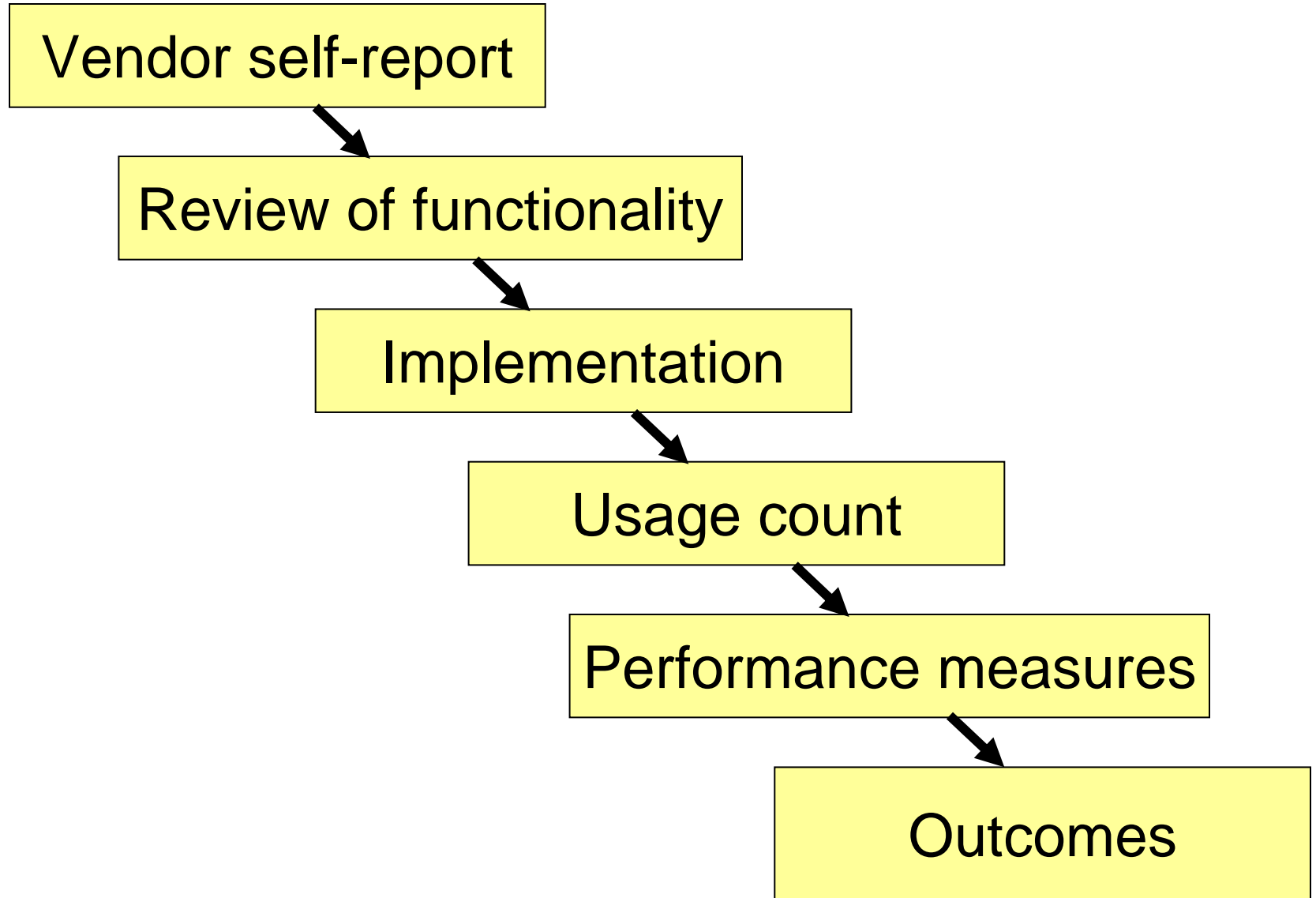
Guideline/measure reporting

- Which guidelines?
 - (e.g.,) NQF, National Priorities Partnership, AQA/HQA, Joint Commission
 - From IOM priority areas and STEEEP framework
 - May be a combination of depth and breadth
- From quality standpoint, object is to recognize local/national need areas, report, and improve

NPP Working Groups

- Reliable and effective management of episodes
- Index of key preventive services
- System level HAI
- Avoidable harms
 - Hospital level mortality
 - Index rate of serious harm
- Care coordination: outpatient focus
- Medication mgmt
- Patient activation/
shared decision-making
- End of life
- 10 most frequent types of overuse

Verification of meaningful use



HIT Policy Committee

- Federal Advisory Committee to make recommendations to ONC regarding nationwide infrastructure and Federal Health IT strategic plan
- Includes policies that will address standards, implementation specifications, certification criteria, authentication, and privacy/security

Other carrots and sticks

State Grants

- Planning and implementation grants established through ONC
- Targeted to states or qualified state-designated entities (not for profit)
- Principal goal is to improve health care through exchange and use of health information
- Required matches beginning in 2011

State grants

- Secretary shall invest through different agencies with expertise (ONC, HRSA, AHRQ, CMS, CDC, IHS)
- Covers health IT architecture, EHR adoption, training and dissemination of best practices, etc.
- Quality focus likely
- NYC, MAeHC projects have been cited as prototypes

Other non-ARRA carrots and sticks

- CMS e-Rx incentive (2008)
- CMS non-pay inpatient events
- NQF never events
- Payer programs

Other ARRA Quality Components

Supporting Implementation

- Goal: Address gaps in adoption
- Health IT Extension Program
 - Created to provide assistance to providers in adopting, implementing and using EHRs
- Health IT Research Center
 - Provide technical assistance in adoption, implementation
 - Foster best practices in implementation and use
- Health IT Regional Extension Centers
 - Local technical assistance and education
 - Support for underserved providers (FQHC, rural, small group)
 - Affiliated with non-profit organizations

Prevention and Wellness fund

- \$1B allocation
 - \$300M to CDC for vaccines R&D
 - \$650M to carry out EBM-based strategies for prevention

Research

- \$1.1B for comparative effectiveness research
- \$10B for cancer / Alzheimer's / heart disease / stem cell research (and NIH facility improvement)
- Challenge grants

Challenge grants - NIH

- 10-CA-101* Cyber-Infrastructure for Health: Building Technologies to Support Data Coordination and Computational Thinking.
- 10-EB-101* Engineering improved quality of health care at a reduced cost.
- 10-HL-101* Develop data sharing and analytic approaches to turn large-scale EHR data into reliable estimates of comparative treatment effects and outcomes of cardiovascular, lung, and blood diseases .
- 10-LM-101* Informatics for post-marketing surveillance.
- 10-LM-102* Advanced decision support for complex clinical decisions.
- 10-OD-101* Adapt existing genetic and clinical databases to make them interoperable for pharmacogenomics studies
- 10-RR-101* Information Technology Demonstration Projects Facilitating Secondary Use of Healthcare Data for Research

Education and Training

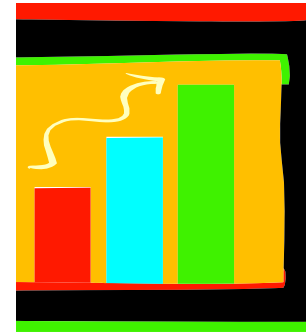
- \$500M for training primary care providers and for offsetting medical school expenses
- \$\$ for training health informatics workers (universities)
- Grants to improve the use of EHRs *in the process of* medical/clinical education (medical schools)
- \$\$ for training in the implementation, best practice, and use of EHRs – (HITRC, extension centers)

Making it Feasible: National Efforts

Connecting EBM to EHRs

- Guidelines are complex - not designed for easy clinical or EHR use
- Difficult for vendors to normalize data if dataset is unbounded
- CDS not easily sharable from site to site
- CPOE and CDS implementations erratic
- Reporting schemes numerous and complex

Quality Organizations



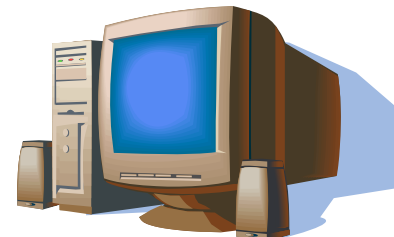
Reporting Agencies

Guideline Developers

**Providers/
Patients**

**CDS
Producers**

**EHR
Vendors**



HITEP – Quality Dataset for EHRs

- NQF panel seeking a core quality data set and standard reporting workflow
- Make new (and old) guidelines EHR-friendly
 - Measurement / Quality Reporting
 - Consistency across vendors and sites
 - Executable / CDS-friendly
- HITEP 1 – 2007-08; HITEP 2 - 2009

AHIC Quality and CDS output

- Quality WG
 - vision/roadmap for incentives, data stewardship, data exchange, quality data set, measure set, coding
- ad hoc CDS workgroup
 - Took off from HHS/AMIA Roadmap for Nat'l Action on CDS
 - Focus on national priorities, establish CDS collaboration entity, CDS sharing conventions and repositories, incentives

Additional Efforts

- CDS Collaboratory - collaboration among Federal organizations on CDS definition, structures, and usage
- AHRQ contracts on CDS sharing
- National Data Stewardship Entity – IOM recommendation for common, consistent measure-data format and reporting mechanism
- HITSP related projects

So What Do You Do?

If you are a provider...

- Funding and support will be available for EHR/eRx systems that support quality
- MU criteria will try to encourage actual MU!
- Funding is front-loaded in time
- Criteria will likely include priority problem areas, CDS
- Implementation support bodies under development

If you are an EHR vendor...

- Data analysis, reporting, CDS, ordering are important for qualification -- ↑demand
- Some previously-difficult markets may open up
- Need increased access to updated knowledge, guidelines, CDS sources – commercial / national
- Follow work on priorities, certification, data standards

If you are a researcher/contractor...

- Increased funding for priority clinical areas
- Challenge grants will come out early
- Funding will support implementation more than usual, as well as research

If you are a payer...

- CMS has now caught on to incentives, thus probably increasing acceptance of yours
- Follow work on consistency of priorities, data standards
- Increased adoption may lead to higher revenue, *if* cost equation makes sense to providers – find equilibrium

Remember why we are here!



Resources

- One-stop shop on the ARRA:
www.himss.org/EconomicStimulus
 - Summary & Analysis
 - FAQs: Gen'l, Privacy & Security, and Funding
 - Incentive Worksheets & Updated News
- HIMSS09 Sessions on ARRA:
www.himssconference.org/education/ESPSSessions.aspx
- CCHIT: www.cchit.org
- HITSP: www.hitsp.org
- ONC: www.hhs.gov/healthit
- NeHC: www.nationalehealth.org

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